

# Dermatology questionnaire

Dear client:

\_\_\_\_\_

We are looking forward to seeing you and your pet. In order to help our students and doctors understand your pet's problems, please complete this questionnaire. Your answers will help us give your pet the best care possible.

Thank you very much!

Your name:

Your pet's name:

After you fill out the questionnaire, please send it back to the Dermatology Service prior to your scheduled appointment.

You may send the questionnaire to us in the way that works best for you:

-- by email: [NCStateDermatology@NCSU.edu](mailto:NCStateDermatology@NCSU.edu)

-- by fax: (919) 513-6563

-- by mail: Dermatology Service, NCSU CVM-VTH  
1052 William Moore Dr., Raleigh, NC 27607

Or press the button on the last page of the form to automatically send it by email.

Your name:

Your pet's name:

## Section 1. What brought you and your pet here today?

1.1 What is your **pet's main problem today?**

Please check **all that apply** and **add details as needed**.

- |  |                                     |
|--|-------------------------------------|
| <input type="checkbox"/> Dandruff:       | <input type="checkbox"/> Odor:      |
| <input type="checkbox"/> Dry skin:       | <input type="checkbox"/> Oily skin: |
| <input type="checkbox"/> Hair loss:      | <input type="checkbox"/> Rash:      |
| <input type="checkbox"/> Itching:        | <input type="checkbox"/> Redness:   |
| <input type="checkbox"/> Something else: |                                     |

1.2 Has your pet ever been **treated for this problem before?**

- No. *Skip to next question.*  
 Yes.

Approximate month and year:

Medications:

Other treatments:

Results of medications and other treatments:

1.3 **How old** was your pet when you first noticed this problem?

- I'm not sure. *Skip to next question.*  
 Age:

1.4 What was the very **first sign** of this problem?

- I'm not sure. *Skip to next question.*  
 Itching.  
 Something other than itching:

1.5 **Where** on your pet's body did the problem begin?

Please check **all that apply** and **add details as needed**.

- |  |                                   |
|--|-----------------------------------|
| <input type="checkbox"/> I'm not sure. <i>Skip to next question.</i> |                                   |
| <input type="checkbox"/> Back:                                       | <input type="checkbox"/> Neck:    |
| <input type="checkbox"/> Chest:                                      | <input type="checkbox"/> Nose:    |
| <input type="checkbox"/> Ears:                                       | <input type="checkbox"/> Paws:    |
| <input type="checkbox"/> Eyes:                                       | <input type="checkbox"/> Rump:    |
| <input type="checkbox"/> Groin:                                      | <input type="checkbox"/> Stomach: |
| <input type="checkbox"/> Legs:                                       | <input type="checkbox"/> Tail:    |
| <input type="checkbox"/> Somewhere else:                             |                                   |

1.6 Has it **spread?**

- No. *Skip to next question.*  
 I'm not sure. *Skip to next question.*  
 Yes. Details:

Your name:

Your pet's name:

1.7 Does it **look different** today?

- No. *Skip to next question.*
- I'm not sure. *Skip to next question.*
- Yes. Details:

1.8 My pet **scratches, rubs, chews, licks, or bites** parts of his/her body.

Please check **all that apply** and **add details as needed**.

- |   |                                  |
|---|----------------------------------|
| <input type="checkbox"/> Abdomen:           | <input type="checkbox"/> Muzzle: |
| <input type="checkbox"/> Axilla (arm pit):  | <input type="checkbox"/> Neck:   |
| <input type="checkbox"/> Back:              | <input type="checkbox"/> Nose:   |
| <input type="checkbox"/> Back legs:         | <input type="checkbox"/> Paws:   |
| <input type="checkbox"/> Chest:             | <input type="checkbox"/> Rump:   |
| <input type="checkbox"/> Eyes:              | <input type="checkbox"/> Tail:   |
| <input type="checkbox"/> Groin:             |                                  |
| <input type="checkbox"/> Somewhere else:    |                                  |
| <input type="checkbox"/> None of the above. |                                  |

1.9 My pet's symptoms seem to get **WORSE** sometimes.

Please check **all that apply** and **add details as needed**.

- |   |   |
|---|---|
| <input type="checkbox"/> In the Spring:                 | <input type="checkbox"/> At a particular time of day: |
| <input type="checkbox"/> In the Fall:                   | <input type="checkbox"/> After eating:                |
| <input type="checkbox"/> In the Summer:                 | <input type="checkbox"/> After taking medication:     |
| <input type="checkbox"/> In the Winter:                 | <input type="checkbox"/> In the house:                |
| <input type="checkbox"/> At night:                      | <input type="checkbox"/> Outside:                     |
| <input type="checkbox"/> In the morning:                |   |
| <input type="checkbox"/> After this situation or event: |   |
| <input type="checkbox"/> None of the above.             |   |

1.10 My pet's symptoms seem to get **BETTER** sometimes.

Please check **all that apply** and **add details as needed**.

- |   |   |
|---|---|
| <input type="checkbox"/> In the Spring:                 | <input type="checkbox"/> At a particular time of day: |
| <input type="checkbox"/> In the Fall:                   | <input type="checkbox"/> After eating:                |
| <input type="checkbox"/> In the Summer:                 | <input type="checkbox"/> After taking medication:     |
| <input type="checkbox"/> In the Winter:                 | <input type="checkbox"/> In the house:                |
| <input type="checkbox"/> At night:                      | <input type="checkbox"/> Outside:                     |
| <input type="checkbox"/> In the morning:                |   |
| <input type="checkbox"/> After this situation or event: |   |
| <input type="checkbox"/> None of the above.             |   |

1.11 My pet **also has some other problems**.

Please check **all that apply** and **add details as needed**.

- |                                      |  |
|--------------------------------------|--|
| <input type="checkbox"/> Coughing:   | <input type="checkbox"/> Diarrhea:           |
| <input type="checkbox"/> Sneezing:   | <input type="checkbox"/> Poor appetite:      |
| <input type="checkbox"/> Runny nose: | <input type="checkbox"/> Excessive appetite: |
| <input type="checkbox"/> Runny eyes: | <input type="checkbox"/> Head shaking:       |
| <input type="checkbox"/> Vomiting:   | <input type="checkbox"/> None of the above.  |

Your name:

Your pet's name:

## Section 2. Your pet's health, history, and habits

- 2.1 Has your pet been **out of his or her usual environment** recently (vacation, play date, day-care, visit to family or friends, kennel, pet-sitter, and so on)?
- No. *Skip to next question.*
- Yes. Details:
- 2.2 What does your pet **eat**?  
Please tell us frequency of meals, amounts, and brands if possible.
- Canned food:  Treats:
- Dry food:  Human food:
- Other:
- 2.3 Has your pet been **neutered**?
- No. *Skip to next question.*  Yes. Age when neutered:
- I'm not sure. *Skip to next question.*
- 2.4 How much time does your pet spend **in the house**?
- Never comes in the house.  Only comes in at night.
- Stays in the house almost all the time.  Other:
- 2.5 How much time does your pet spend **outside**?
- Never goes outside.  Only goes out at night.
- Stays outside almost all the time.  Other:
- 2.6 Do you (or someone else) **bathe/groom your pet at home**?
- No. *Skip to next question.*
- Yes. Frequency and products:
- 2.7 Do you (or someone else) **bathe/groom your pet somewhere else**?
- No. *Skip to next question.*
- Yes. Frequency and products:
- 2.8 Does your pet have any **parasitic problems**?
- No. *Skip to next question.*  I'm not sure.
- Yes, now. Details:
- Yes, in the past. Details:
- 2.9 Does your pet have any **other illnesses**?
- No. *Skip to next question.*  Yes, now. Details:
- I'm not sure.  Yes, in the past. Details:

Your name:

Your pet's name:

### Section 3. Other animals and people in your household

- 3.1 Do you have any other **indoor** animals?  
 No. *Skip to question 3.3.*  
 Yes. Details:
- 3.2 Do any of your other **indoor animals have skin problems**?  
 No. *Skip to next question.*  
 Yes. Details:
- 3.3 Do you have any other **outdoor** animals?  
 No. *Skip to question 3.5.*  
 Yes. Details:
- 3.4 Do any of your other **outdoor animals have skin problems**?  
 No. *Skip to next question.*  
 Yes. Details:
- 3.5 Do any **people in your house have skin problems**?  
 No. *Skip to next question.*  
 Yes. Details:

### Section 4. Fleas and flea-control in your household

- 4.1 A. Does your pet have **fleas**?  
 No, not now.  
 Yes, now.  
 Yes, in the past. I saw the **last flea** (date):
- B. Do you use flea control products on your pet?  
No.  
Yes. I use:
- 4.2 Do you use **flea-control products inside** your house? That is, on your carpet, furniture, and so on. This question does NOT apply to products used directly on your animal(s).  
 No. *Skip to next question.*  
 Yes. Brand and frequency of use:
- 4.3 Do you use **flea-control products outside** your house? That is, on your lawn, patio, deck, shrubs, and so on. This question does NOT apply to products used directly on your animal(s).  
 No. *Skip to next question.*  
 Yes. Brand and frequency of use:
- 4.4 If you do use flea-control products (inside, outside, or on your animals) **when** do you use them? Please check **all that apply** and **add details as needed**.  
 I don't use any flea-control products.  
 Year-round  
 Spring  
 Other:  
 Summer  
 Fall  
 Winter